CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

14th June 2017

Report title	Overview of Primary Care Strategy and Estates Update
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing
Accountable director	Ros Jervis, Wellbeing
Originating service	Wolverhampton CCG
Accountable employee(s)	Adam Hadley — Group Manager – Democracy Tel — 01902 555043 Email — Adam.hadley@wolverhampton.gov.uk
Report to be/has been considered by	Health and Wellbeing Board

---

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Receive and discuss this report.
2. Note the continued achievements being realised by the CCG within Primary Care and Estates.

1.0 Purpose

1.1 Provide assurance on progress made to date in relation to achievements that have been realised from the programme of work attached to the CCGs Primary Care Strategy & Estates and confirm the work which is currently underway in the next phase implementation.

The report also confirms where assurance has been received from the CCG Primary Care committee in respect of new models of care demonstrating how practices have aligned with their preferred model & how working at scale is maturing.

The outcome of discussions at national level in respect of CCGs responsive plan that seeks to address the actions required to implement the GPFV is also confirmed.

2.0 Background

2.1 The CCGs Primary Care Strategy was ratified by the Governing Body in January 2016 in recognition of the changing demands in primary care. The programme of work was launched in the summer of 2016 and this report focuses on the achievements that have been realised since the programme of work commenced.

2.2 The CCGs vision is to achieve universally accessible high quality out of hospital services that promote the health and wellbeing of our local community, ensuring that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and also reduce health inequalities

3.0 PRIMARY CARE STRATEGY COMMITTEE

3.1 Since the programme of work was launched in the summer of 2016 a number of objectives have been achieved through the work of each task and finish group.

Task and Finish Groups

3.2 The individual Task and Finish Groups work programme are up and running and they each have identified priorities for the current quarter (April to June 2017). This includes milestones which are due to commence or are due to be completed within this quarter. It does not include any existing programmes of work which are currently in progress and have a completion date after June 2017.

3.3 Whilst there are risks attached to the delivery of this programme of work there are no red risks captured on the risk register at this stage, this was verified through discussions held at the Primary Care Commissioning Committee meeting in April.

4.0 NEW MODELS OF CARE

4.1 There are 45 practices within the membership of Wolverhampton CCG, almost all practices have aligned with like-minded practices to enable them to work together with a view to reviewing health care needs for their population(s) and where feasible exploring opportunities to share the workload through working at scale. Each group has identified the priorities they feel are most important for their population and comprise of some of the following:-

i. Improving access for patients with diabetes
ii. Improving access for patients during the evening & weekends
iii. Adopting pro-active management of patients with frailty
iv. Using a risk based approach to managing patients with long term conditions

4.2 The current practice groupings are largely attached to the Primary Care Home Model where practices work together to serve a population of in the region of 30-50,000 patients to provide population based complete care in conjunction with health and social care partners and the voluntary sector. This enables patients to receive the right care, first time, personalised to their needs through a strong focus on partnership working. The primary care home model is owned and lead by our general practitioners within each practice who continue to engage with their clinical peers to ensure they achieve a consistency of approach in the way care is provided to their patients.

Practice Group	Number of Practices	Population Size
Primary Care Home 1	9	58,388
Primary Care Home 2	8	50,266
Medical Chambers	21	130,500
Vertical Integration	5	30,350
Not Yet Aligned	2	5,477

Discussions are taking place with practice group leads to identify how those groups can be aligned within the boundaries of the three localities, this will enable the Primary Care Home Model to be further developed by all practices within Primary Care Home 1, 2 and Medical Chambers. Further discussions with practices not yet aligned and vertical integration will also take place to ensure equity of delivery of patient care.

5.0 GENERAL PRACTICE FORWARD VIEW

5.1 As a result of feedback from NHS England in relation to the CCGs second stage implementation plan for the GPFV a range of supplementary information was provided to the regional team in a revised plan. The plan has since been confirmed as fully assured and a programme of work is well underway to implement each of the projects detailed within the plan. The committee will receive formal reports on all live GPFV projects from May 2017 onwards, this information will be reflected in future reports of the committee to Governing Body.

6.0 ESTATES UPDATE

6.1 Better Care Fund (BCF) Hub Locality update - This programme of work is predicated upon the procurement of an external expert company to assess the estates needs of Wolverhampton as a whole from a health and social care point of view. The successful provider of the service is being tasked but not limited to scoping health and social care requirements across the city based upon **needs**. This will involve working with all organisations to gather data which can be overlaid to identify geographical health and social care requirements. The outcome from this succinct piece of work will be used to inform the requirement (or not) for potential 'Hubs' across the City. The work is being overseen by the Local Estates Forum (LEF) which is a strategic forum with executive representation from all organisations across health and social care in Wolverhampton. Other updates around BCF – BCF estates leads have been identified for each locality. The leads have been tasked with finding suitable locations for the co-location of multi-disciplinary teams (MDTs (administrative, not clinical at this stage)) – this group meets regularly under the direction of the BCF Programme Board.

6.2 BCF Hub Locality Next Steps - Awaiting outcome of the procurement of the Service Strategy provider and the recommendations from that work. A list of administrative bases for BCF MDT's will be presented to the next Programme Board.

6.3 Estates Prioritisation Update – The CCG has commissioned the completion of an independent prioritisation exercise, which is near completion. This has involved a review of all GP Practice buildings to include the current state of repair, room utilisation, cost, etc. Final areas being added include Infection Prevention, capacity and Primary Care Strategy support weighting. This will be presented to the Capital Review Group clinical representative for comments before being finalised and presented to the CCG Governing body with associated recommendations. The timescale for the document going to Governing Body is July 2017.

6.4 Estates Prioritisation Next Steps – The document is near completion; IP and Capacity have been included in the document. There are a few outstanding items of information which will be collated and added over the next two weeks. The document will then be reviewed by the CRG clinical lead before being finalised and readied for the Governing Body.

6.5 Primary Care Estates update - There are a number of practices within Wolverhampton working on proposed re-developments/relocations. The CCG is engaging with these practices to offer support where necessary, bearing in mind the imminent outcome from the independent prioritisation exercise. Draft papers have been developed for each locality that identify potential developments within each of the three localities.

6.6 Primary Care Estates Next Steps – To work with the identified practices so that the necessary background information is included in the paper. This will then be appended to the outcome of the prioritisation exercise as necessary. The full

documentation will be presented to the Governing Body for a direction in Primary Care Estates in line with the Primary Care Strategy.

7.0 CLINICAL VIEW

7.1 There are a range of clinical and non-clinical professionals leading this process in order to ensure that the leadership decisions are clinically driven. Clinical representation at many Task and Finish Groups takes place on a regular basis.

8.0 PATIENT AND PUBLIC VIEW

8.1 Whilst patients and the public were engaged in the development of the strategy and a commissioning intentions event held in the summer specific to primary care the Governing Body should note that Practice based Patient Participation Groups are being encouraged to ensure their work with the practice(s) encompasses new models of care and the importance of patient and public engagement moving forward.

8.2 An update on Primary Care was provided to the Patient Participation Group Chairs in March, whilst this was welcomed they have requested further clarity regarding their involvement in the future in discussions with their respective models of care/practice groupings. Therefore, arrangements are being made for each group of PPG Chairs to meet with the CCG and the Group Lead(s) to discuss how this will be achieved and to ensure patients and the public are invited to share their suggestions on areas for improvement and take part in discussions about changes affecting patients.

9.0 RISKS AND IMPLICATIONS

Key Risks

8.1 The Primary Care Strategy Committee has in place a risk register that has begun to capture the profile of risks associated with the program of work. Risks pertaining to the program are reviewed at each meeting and at this stage there are no red risks to raise with the Governing Body.

Financial and Resource Implications

8.2 At this stage there are no financial and resource implications for the Governing Body to consider, representation and involvement from finance colleagues at committee and tasks and finish group level will enable appropriate discussions to take place in a timely manner.

Quality and Safety Implications

8.3 Patient safety is first and foremost, the experience of patients accessing primary medical services as the programme becomes more established is anticipated to be met with positive experiences of care. The CCG quality team will be engaged accordingly as service design takes place and evaluation of existing care delivery is undertaken.

Equality Implications

8.4 The Strategy has a full equality analysis in place. This will require periodic review during the implementation phase.

Medicines Management Implications

8.5 The role of clinical pharmacist is an area of specific attention within the programme of work. A task and finish group has been established to ensure this role is utilised with maximum impact in the future.

Legal and Policy Implications

8.6 The Primary Care Strategy demonstrates how the CCG seeks to satisfy its statutory duties and takes account of the key principles defined within the General Practice Five Year Forward View.